1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06712 Reg. Dist. No. 06698

1. PLACE OF DEATH
a. COUNTY: HARFORD MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JOPPA
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 409 Old Philadelphia Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): JOPPA
d. STREET ADDRESS: 409 Old Philadelphia Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARL Middle AUGUST FRANK Last ANDERSON
4. DATE OF DEATH: Month MAY Day 17 Year 1967
5. SEX: M
6. COLOR OR RACE: CAU
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: SEPT 5, 1905
9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supt. Pipe Shop
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt-Ret.
11. BIRTHPLACE (State or foreign country): Joppa, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl A. Anderson
14. MOTHER'S MAIDEN NAME: Barbara Fisher

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 220-20-7276
17. INFORMANT: DOROTHY ANDERSON (WIFE) Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: INSTANT
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. NO
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W Heuman M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D
DEPUTY MEDICAL EXAMINER ☒
MAY 17, 1967 DATE SIGNED

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 20, 1967
22c. NAME OF CEMETERY OR CREMATORY: Trinity Lutheran Cemetery
22d. LOCATION (City, town, or county): Joppa (State): Harford Md

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
24a. REC'D BY REGISTRAR DATE: MAY 19 1967
24b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06713

CERTIFICATE OF DEATH

06699

1. PLACE OF DEATH
a. COUNTY: HARFORD
MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 2days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress): HARFord Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: 400 South Main Street (~~Rt Bairds Alley~~)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace Middle: Madeline Lost: Bailey

4. DATE OF DEATH: Month: May Day: 13 Year: 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 1, 1921
9. AGE (In years last birthday): 46 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary
10b. KIND OF BUSINESS OR INDUSTRY: Civil Service
11. BIRTHPLACE (County & State, or foreign country): Md. (Harford Co.)
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: W. Sanner Bailey
14. MOTHER'S MAIDEN NAME: Hattie Viola Preston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give wor or dotes of service):
16. SOCIAL SECURITY NO.: 214-12-9257
17. INFORMANT (Brother) 838-6326 Address: Mr. Tom Bailey, 12 Forest Drive, Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemic Shock — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
(b): Gram-Negative Bacteria + Enteritis — 8 days
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
(2) Lacunes Cerebri (3) Dehydration + hypokalemia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Yeor Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 12, 1967, to May 13, 1967 that (I) (we) last saw the deceased alive an May 13, 1967, and that death occurred at 12:30 P M, from causes and an the date stated above.

22a. SIGNATURE: Edward C. Loomis M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/13/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loomis M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co, Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25a. REC'D BY REGISTRAR
DATE: 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

(Joseph William Foster)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06714

CERTIFICATE OF DEATH

06700

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 4 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 124 Wilson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLA — Middle: Josephine — Last: BROWN

4. DATE OF DEATH: Month: MAY — Day: 27 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG. 28, 1902

9. AGE (In years last birthday): 64 Yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): MASS.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: WILLIS JACOBS

14. MOTHER'S MAIDEN NAME: GEORGIANA BOYD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-46-9262

17. INFORMANT: Mr. FOREST E. BROWN — Address: 124 WILSON ST. HAVRE DE GRACE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3-4 days
DUE TO (b): Arteriosclerotic Cardiovascular disease — 3 years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/24, 1967 to May 27, 1967 that (I) (we) last saw the deceased alive on May 27, 1967, and that death occurred at 1 p.m. from causes and on the date stated above.

22a. SIGNATURE: Edward Coons, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5/29/67

22c. PHYSICIAN'S NAME (Type): Edward C. Coons, M.D. — 22d. ADDRESS: Havre de Grace, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: MAY 31, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: HARFORD MEMORIAL GARDENS — 23d. LOCATION (City or Town) (County) (State): HARFORD Co. MD.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE MD

25a. REC'D BY REGISTRAR DATE: JUN 1 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06715 — 06701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 (M)

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground c. LENGTH OF STAY IN 1b: 16 hrs 45 min	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood Arsenal
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital	d. STREET ADDRESS: 6201 C Baker Circle e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Lisa	(none)	CLARK	May	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Negro	NEVER MARRIED ☒	May 16, 1967	yrs.		16 / 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
N/A	N/A	Harford, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Roosevelt Clark	Minnie R. Bottoms

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
N/A	N/A	N/A	Mother (Same as above)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 16 hrs 45min
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that ~~I~~ (this hospital) attended the deceased from 16 May, 19 67, to May 17, 19 67 that ~~I~~ (we) last saw the deceased alive on May 17 19 67, and that death occurred at 12:55 AM, from causes and on the date stated above.

22a. SIGNATURE	M.D.	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22b. DATE SIGNED
Thomas J. Green		☐	☐	☒	17 May 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
THOMAS J. GREEN, CPT, MC	Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 19, 1967	A.P.G. Post Cemetery	Aberdeen Proving Ground, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md.	MAY 29 1967	J. Charles Judge

7-270478

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06716

CERTIFICATE OF DEATH

06702

1. **PLACE OF DEATH** a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 1 hour
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission) a. STATE: Md. b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen 21001
d. STREET ADDRESS: 44 Fenway St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: MARIE Middle: F. Last: COPELAND
4. **DATE OF DEATH**: Month: MAY Day: 16 Year: 1967

5. SEX: Female
6. COLOR OR RACE: C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-12-22
9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Air-Force Exchange
11. BIRTHPLACE (County & State, or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Brown
14. MOTHER'S MAIDEN NAME: Josephine Henderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 231-22-3346
17. INFORMANT: Mr. John E. Copeland, Aberdeen, Md. Address: 44 Fenway St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Hypertensive Cardiovascular disease
DUE TO
(c): Coronary Thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 12, 1966 to MAY 16, 1967 that (I) (we) last saw the deceased alive on MAY 16 1967, and that death occurred at 10:30 A M, from causes and on the date stated above.

22a. SIGNATURE: George T. Stansbury, M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/67
22c. PHYSICIAN'S NAME (Type): George T. Stansbury
22d. ADDRESS: 569 Revolution St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 21, 1967
23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill Christian Cem.
23d. LOCATION (City or Town) (County) (State): Holland Virginia

24. FUNERAL DIRECTOR: Elmer E. Billick ADDRESS: 55 & Lewis St Havre de Grace, Md.
25a. REC'D BY REGISTRAR DATE: MAY 22 1967
25b. REGISTRAR'S SIGNATURE: H. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06717

CERTIFICATE OF DEATH

06703

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 1 yr. 2 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Convalescing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Bel Air
d. STREET ADDRESS: 404 Giles Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: IRIS — Middle: V. — Last: CULLUM

4. DATE OF DEATH: Month: MAY — Day: 17 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 1, 1880

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Harford County, Md.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Kyle

14. MOTHER'S MAIDEN NAME: Annie Bird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 220-54-9070-T

17. INFORMANT: Mrs. Flossie V. Hooper, Address: Bel Air, Md. 404 Giles St.,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage, terminating — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
(b):
Conditions, if ony, which gave rise to immediote couse (a), stoting the underlying couse lost.
DUE TO
(c): Chronic Hypertensive ASCVD — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4/14/ , 1956 , to 5/17 , 1967 , that (I) saw the deceased last alive on 5/16/ 1967 , and that death occurred at 10 a. M, from causes and on the date stated above.

22a. SIGNATURE: Willard P. Hudson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/18/1967

22c. PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22d. ADDRESS: Forest Hill, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 19, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air Harford Md

24. FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009

25a. REC'D BY REGISTRAR DATE: MAY 19 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06718 06704

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Hanford
MARYLAND: Md
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brevin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: 3807 Fleetwood Balti.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
d. STREET ADDRESS: 4215 Union St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Charlotte Middle: Annie Last: Cundiff

4. DATE OF DEATH: Month: 5- Day: 18 Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 3-9-1893
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Knoxville Tenn
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wm C Sheen
14. MOTHER'S MAIDEN NAME: Janet Bowman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service):
16. SOCIAL SECURITY NO.: 214-10-2428
17. INFORMANT: Brevin Address: 4215 Union St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro-vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): arterio sclerosis generalized — 1 year
DUE TO
(c): Diabetes mellitus

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Nat While at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/6/, 1967, to 5/18/, 1967, that (I) (we) last saw the deceased alive on 5/18/ 1967, and that death occurred at / P M, from causes and on the date stoted above.

22a. SIGNATURE: Chas L. McComas M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/18/67
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-22-1967
23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cem
23d. LOCATION (City or Town) (County) (State): Baltimore Md

24. FUNERAL DIRECTOR: Lassahn Funeral Home
ADDRESS: 7401 Belair Road (36)

25a. REC'D BY REGISTRAR DATE: MAY 23 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06713 — 06705

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
d. STREET ADDRESS: 240 Bloomsbury Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DAVid — Middle: R[illegible] — Last: Curry

4. DATE OF DEATH: Month: MAY — Day: 6 — Year: 1967

5. SEX: MAle

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Mar. 11, 1911

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOILER FIREMAN

10b. KIND OF BUSINESS OR INDUSTRY: DISABILITY

11. BIRTHPLACE (County & State, or foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE A. CURRY

14. MOTHER'S MAIDEN NAME: SARAH JANE MORRIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 214-18-3970

17. INFORMANT: Mrs. Latita M. CURRY, Address: HAVRE DE GRACE, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST — INTERVAL BETWEEN ONSET AND DEATH: MINUTES
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): MYOCARDIAL INFARCTION — HOURS
DUE TO
(c): ASCUS — DAYS / YEARS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): PULMONARY EMPHYSEMA

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. / p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/4, 1967 to 5/6, 1967, that (I) (we) last saw the deceased alive on May 6 1967 and that death occurred at 3:35 M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5-6-67

22c. PHYSICIAN'S NAME (Type): S. LEYTE-VIDAL

22d. ADDRESS: 114 W. BEL AIR AVE, ABERDEEN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: May 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: ASBURY CEM.

23d. LOCATION (City or Town) (County) (State): CECIL Co. MD.

24. FUNERAL DIRECTOR: K. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: MAY 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06720 06706

1. PLACE OF DEATH
a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Street
c. LENGTH OF STAY IN 1b: 33 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Prospect Road

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Street
d. STREET ADDRESS: Prospect Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First IRENE Middle T. Last DAVIS

4. DATE OF DEATH: Month May Day 22, Year 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 15,1903
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Delta, Pa.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Tarbert
14. MOTHER'S MAIDEN NAME: Mary Grimes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give wor or dates of service)
16. SOCIAL SECURITY NO.: 220-12-4272
17. INFORMANT Address: Thomas S. Davis, Street, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 32 days
DUE TO (b): Advanced Arteriosclerosis + Cerebral Thrombosis — 6 mo.
DUE TO and (c): Right peinophric abscess + non-functioning kidney — 8 years.
332 x
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertension - Moabid pneumonia (3days)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept, 19 57, to 22 May, 1967, that (I) (we) last saw the deceased alive an 22 May, 19 67, and that death accurred at 4:35 P.M, fram causes and an the date stated abave.

22a. SIGNATURE: Edwin W. Whiteford Jr. M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: May 23,1967
22c. PHYSICIAN'S NAME (Type): Edwin W. Whiteford, Jr. M.D.
22d. ADDRESS: Whiteford, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 25,1967
23c. NAME OF CEMETERY OR CREMATORY: Mt. Vernon
23d. LOCATION (City or Town) (County) (State): Whiteford, Harford, Md.

24. FUNERAL DIRECTOR: John H. Harkins
ADDRESS: Delta, Pa.
25a. REC'D BY REGISTRAR DATE: MAY 25 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06721

CERTIFICATE OF DEATH

06708

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Rural-Street
c. LENGTH OF STAY IN 1b: 46 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Doyle Road

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give neorest town): Rural- Street 12-1
d. STREET ADDRESS: Doyle Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: J. — Middle: KEMMETT — Lost: DOYLE

4. DATE OF DEATH: Month: May — Doy: 29, — Year: 19 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov.8,1888
9. AGE (In yeors last birthdoy): 78 yrs.
IF UNDER 1 YEAR: Months / Doys
IF UNDER 24 HRS.: Hours / Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (County & Stote, or foreign country): Harford Co.,Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J. Doyle
14. MOTHER'S MAIDEN NAME: Mary M. Frederick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 219-36-0209
17. INFORMANT Address: Thomas F. Doyle, Street, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1.9 MIN
DUE TO
(b): Advanced arteriosclerotic cardiovasular disease — 6 yr.
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Exogenous obesity; osteoarthritis - knees - spastic colon
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19
20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐
20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)
20f. (City or town) (County) (Stote)

21. I certify that (I) (this haspital) attended the deceased from April, 1960 to 24 May, 1967, that (I) ~~(we)~~ last saw the deceased alive an 22 May 1967, and that death occurred at 6:45 P M, from causes and an the date stated abave.

22o. SIGNATURE: Edwin W. Whiteford Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 31, 1967
22c. PHYSICIAN'S NAME (Type): Edwin W. Whiteford, Jr. MD
22d. ADDRESS: Whiteford, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 1, 1967
23c. NAME OF CEMETERY OR CREMATORY: Emory
23d. LOCATION (City or Town) (County) (Stote): Street, Harford Co., Md.

24. FUNERAL DIRECTOR: John T. Hawkins
ADDRESS: Delta, Pa.
25o. REC'D BY REGISTRAR DATE: JUN 2 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06722

CERTIFICATE OF DEATH

06709

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 126 So. Wash. St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANNA — Middle: LAURA — Last: ERWIN

4. DATE OF DEATH: Month: May — Day: 6 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 29, 1897

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or Foreign country): MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Francis Crawford

14. MOTHER'S MAIDEN NAME: Laura V. Mc Ewing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 217-07-7446

17. INFORMANT: Mrs. Virginia E. Holcomb — Address: Aberdeen, Md. R.D. #1 Box 254A.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 27, 1967, to May 6, 1967 that (I) (we) last saw the deceased alive on May 6 1967, and that death occurred at 7 ~~P~~ A M, from causes and on the date stated above.

22a. SIGNATURE: Frank E. McDonnell — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/6/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 9 1967

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Harford Co. Md.

24. FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

25a. RECD. BY REGISTRAR DATE: MAY 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06723 06710

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: Magnolia Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lorean — Middle: May — Last: Faine

4. DATE OF DEATH: Month: 5 — Day: 4 — Year: 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 29, 1909
9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Presser
10b. KIND OF BUSINESS OR INDUSTRY: Sewing Factory
11. BIRTHPLACE (County & State, or foreign country): W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack Martin
14. MOTHER'S MAIDEN NAME: Dirama Arrow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 233-28-8342
17. INFORMANT Address: Mr. Troy Faine, Magnolia Rd., Joppa, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Left cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO (b): Calcinomatosis — left breast cancer. — 2 yrs.
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Part I or Part II af item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb, 1965 to May, 1967, that (I) (we) last saw the deceased alive on May 4 1967, and that death occurred at 9:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: W. H. Sadowsky M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/4/67
22c. PHYSICIAN'S NAME (Type): W. H. SADOWSKY
22d. ADDRESS: 504 Lewis St. Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 8, 1967
23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Aberdeen R.D. Harford Md

24. FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. REC'D BY REGISTRAR DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06724

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06711

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 4mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 614 Chapel Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace — Middle: — Last: Farrell

4. DATE OF DEATH: Month: May — Day: 2 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/21/1895

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Scotland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Cairns

14. MOTHER'S MAIDEN NAME: Grace McGregor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT: T.J. Farrell — Address: 614 Chapel Terrace Havre de Grace, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic C V Disease — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer M.D.

CHIEF MEDICAL EXAMINER ☐ (3d Am. W.)
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 5-3-67

22a. BURIAL, CREMATION, REMOVAL (Specify): 5/6/67

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: Angel Hill

22d. LOCATION (City, town, or county) (State): Havre de Grace, Md

23. FUNERAL DIRECTOR: Ramsay Funeral Home — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: MAY 8 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06725 06712

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Churchville
c. LENGTH OF STAY IN 1b: 2 Yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Rockdale Ave.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Churchville RD #1 Box 627
d. STREET ADDRESS: Rockdale Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grant — Middle: Hazel — Last: Good

4. DATE OF DEATH: Month: May — Day: 2, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/27/1906

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Gen. farming

11. BIRTHPLACE (County & State, or foreign country): Pocahontas Co. W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Kenny Newton Good

14. MOTHER'S MAIDEN NAME: Maudie Ann Morrison

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give war or dates of service): ---

17. INFORMANT: 220-12-5814 Opal A. Good — Address: RD #1 Box 627 Churchville, Md. 21028

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.
DUE TO (b): Arteriosclerotic coronary artery disease — 15 yr.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Gastric carcinoma c obstruction at esophageal area

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Oct 1957 to 2 May 1967, that (I) (~~we~~) last saw the deceased alive on 2 May 1967, and that death occurred at 8:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Edwin W Whiteford Jr MD — M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 3 May 1967
22c. PHYSICIAN'S NAME (Type): Edwin W. Whiteford Jr.
22d. ADDRESS: Whiteford, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/5/1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Mem. Gardens
23d. LOCATION (City, town or county) (State): Bel Air Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz
ADDRESS: Jarrettsville, Md. 21084
25a. RECD BY REGISTRAR DATE: MAY 4 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A1S (4)
20M S-63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06726 — 06713

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverside Grove
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 36 Hanover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Roosevelt — Middle: Gregory — Last: Tr-

4. DATE OF DEATH: Month: May — Day: 11 — Year: 1967

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 9-27-47

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Co.,

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Roosevelt A. Gregory Sr.

14. MOTHER'S MAIDEN NAME: Mary M. Mayo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 224-66-6211

17. INFORMANT — Address: Wife, Same as 2 C & D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Rupture liver
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fork lift overturned on him

20c. TIME OF INJURY Month, Day, Year: Hour 4:30 p.m. 5-4-1967

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Moores Store

20f. (City or town) Aberdeen (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
EXAMINER'S NAME (Type): Gerald C. Palmer, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county): Bel Air, Md.

22. DATE SIGNED: 5-12-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 14 May 67

23c. NAME OF CEMETERY OR CREMATORY: South Hill Cemetery

23d. LOCATION (City or Town) South Hill, (County) (State) Virginia

24. FUNERAL DIRECTOR: Webster Macomber Sr.
ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 15 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06727 06714

1 M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: P.O. Box 62
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: Harry — Last: Hanna — SR.
4. DATE OF DEATH: Month: May — Day: 16 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 11, 1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman
10b. KIND OF BUSINESS OR INDUSTRY: auto accessories
11. BIRTHPLACE (County & State, or foreign country): W. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Calvin H. Hanna
14. MOTHER'S MAIDEN NAME: Mary Kincaid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 234-20-7219
17. INFORMANT — Address: Mrs. Vera G. Hanna, Box 62, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO: —
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO: —
(c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Vascular thrombosis + A.S.C.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 11, 1967, to May 16, 1967, that (I) (we) last saw the deceased alive on May 16, 1967, and that death occurred at 7:25 A.M., from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/16/67
22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.
22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air Harford Md

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md.
25a. FILED BY REGISTRAR DATE: MAY 18 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06723 06715

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood Arsenal
d. STREET ADDRESS: 6508 Hawthorne Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Everette Middle Eugene Last Hicks

4. DATE OF DEATH: Month May Day 8 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 27 June 35

9. AGE (In years last birthday): 31 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (County & State, or foreign country): Prescott, Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George W. Hicks

14. MOTHER'S MAIDEN NAME: Laura Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): Feb 55 - May 67

16. SOCIAL SECURITY NO.: 578-48-8582

17. INFORMANT: Personnel Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarct(?) — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Myocarditis(?)
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I (this hospital) attended the deceased from 8 May, 1967, to 8 May, 1967, that I (we) last saw the deceased alive on 8 May 1967, and that death occurred at 5:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: Thomas Fraher MD M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8 May 1967

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, M.D.

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: May 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery

23d. LOCATION (City, town or county) (State): Prescott, Arkansas

24. FUNERAL DIRECTOR: Lee A. Patterson & Son

ADDRESS: Lee A. Patterson & Son, Perryville, Md.

25a. REC'D BY REGISTRAR DATE: MAY 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06723

CERTIFICATE OF DEATH

D6716

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: [illegible] Rt 1 Box 42
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Grover — Last: Hiob Sr.

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 23 April 1885

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electro Type & Farmer)

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Md. (Balto.)

12. CITIZEN OF WHAT COUNTRY? U.S

13. FATHER'S NAME: Charles Casper Hiob (D)

14. MOTHER'S MAIDEN NAME: Catherine Kampe (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 213-05-8769-A)

17. INFORMANT — Address: Wife, Same as 2 C & D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia and — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Congestive Heart Failure — 1 yr
DUE TO
(c): Generalized Arteriosclerosis — 5 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1, 1960, to May 1, 1967, that (I) (we) last saw the deceased alive on May 1 1967, and that death occurred at 1:45 p.m. from causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/1/67

22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD

22d. ADDRESS: Darlington Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/4/67

23c. NAME OF CEMETERY OR CREMATORY: St Paul Lutheran Cemetery)

23d. LOCATION (City or Town) (County) (State): Aberdeen, Md.

24. FUNERAL DIRECTOR: Webster Waconda Sr. — ADDRESS: Harding Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 4 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06730 06717

1. PLACE OF DEATH
a. COUNTY: Har Ford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Har Ford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit
d. STREET ADDRESS: 38 Granite Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: F — Last: Holland

4. DATE OF DEATH: Month: 5 — Day: 13 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 25, 1907
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Civil Ser. Bainbridge
11. BIRTHPLACE (County & State, or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John F. Holland, Sr.
14. MOTHER'S MAIDEN NAME: Minnie L. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO.: 557-32-1505
17. INFORMANT: Cecil E. Holland, 8364 Jefferson St., N.E. Address Washington, D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b): Cerebral Seleros — Duration
DUE TO
(c): Arterio - Sclerosis — Dupr
331X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 17, 1967 to May 8, 1967 that (I) (we) last saw the deceased alive an May 8 1967, and that death accurred at 5:00 P.M, from causes and an the date stated abave.

22a. SIGNATURE: Clarence I. Benson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 13-67
22c. PHYSICIAN'S NAME (Type): Clarence I. Benson, M.D.
22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 18, 1967
23c. NAME OF CEMETERY OR CREMATORY: Lincoln, Memorial Cemetery
23d. LOCATION (City or Town) (County) (State): Washington, D. C.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son ADDRESS: Perryville, Maryland
25a. REC'D BY REGISTRAR DATE MAY 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physicion.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06731

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06718

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): DOA Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 47 Bush Chapel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Douglas — Middle: Hundley — Last:
4. DATE OF DEATH: Month: May — Day: 5 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct. 25, 1907
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Odd Jobs
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No record
14. MOTHER'S MAIDEN NAME: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
16. (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 224-22-7180
17. INFORMANT: Mrs. Mary Eliza Hundley — Address: Box 47A Bush Chapel Rd. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
Address (Street, city, town, or county):
22. DATE SIGNED: 5-6-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 9, 1967
23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cem.
23d. LOCATION (City, town or county) (State): Aberdeen, Harford Co. Md.

24. FUNERAL DIRECTOR: Otelia J Bullock — ADDRESS: Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: MAY 8 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15ME (5) 5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06732 06719

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
c. LENGTH OF STAY IN 1b 40 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) none

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
d. STREET ADDRESS 2821 Willoughby Beach Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ARTHUR Middle AUGUST Last KERSHAW
4. DATE OF DEATH Month May Day 11 Year 19 67
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Nov. 1, 1890
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter
10b. KIND OF BUSINESS OR INDUSTRY U.S.Govt - Ret.
11. BIRTHPLACE (County & State, or foreign country) Detroit, Michigan
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Theodore Kershaw
14. MOTHER'S MAIDEN NAME Mary Boelter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WWI
16. SOCIAL SECURITY NO. 220-20-7979
17. INFORMANT Mrs. Edna Viola Kershaw, Address Edgewood, Md. 2821 Willoughby Beach Road

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ACUTE CONGESTIVE FAILURE — INTERVAL BETWEEN ONSET AND DEATH 30 MIN
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE — OVER 12 YRS
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 13, 1954 to MAY 11, 1967 that (I) (we) last saw the deceased alive on MAY 11 1967, and that death occurred at 7:55 A.M. from causes and on the date stated above.

22a. SIGNATURE Philip W Heuman M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) Philip W. Heuman, M.D.
22d. ADDRESS 307 Hickory Avenue, Bel Air, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF May 15, 1967
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery
23d. LOCATION (City or Town) Baltimore (County) (State) Md
24. FUNERAL DIRECTOR ADDRESS Howard K. McComas & Son, Abingdon, Md. 21009
25a. REC'D BY REGISTRAR DATE MAY 15 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to buriol, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06720

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston 12-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Winston Middle: Thomas Lost: Kourey

4. DATE OF DEATH: Month: May Day: 3 Year: 19 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 5/30/1927

9. AGE (In years last birthday): 39 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BALTO. TRANSIT CO.

10b. KIND OF BUSINESS OR INDUSTRY: TRANSPORTATION

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SALEM W. KOUREY

14. MOTHER'S MAIDEN NAME: HELEN MEYER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): YES WWII

16. SOCIAL SECURITY NO.: 219-22-8165

17. INFORMANT Address: DR. SALEM W. KOUREY (SAME)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Multiple Sclerosis
345 X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Gerald C Palmer M.D.

EXAMINER'S NAME (Type): Gerald C Palmer (M.D.)

CHIEF MEDICAL EXAMINER [ ] Bel Air, Md.
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

22. DATE SIGNED: 5-3-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/6/1967

23c. NAME OF CEMETERY OR CREMATORY: Loudon Park

23d LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: H. W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.

25a. REC'D BY REGISTRAR: MAY 5 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06734

CERTIFICATE OF DEATH

06721

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa,
c. LENGTH OF STAY IN 1b: 1 year
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): none

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa
d. STREET ADDRESS: 1407 Old Joppa Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: May — Last: Limbert

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1892

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dress Maker

10b. KIND OF BUSINESS OR INDUSTRY: Mfg.

11. BIRTHPLACE (County & State, or foreign country): Tower City, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Shomper

14. MOTHER'S MAIDEN NAME: Tammie Morgan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 162-07-8362

17. INFORMANT: Irvin Limbert, 1407 Old Joppa Rd., Joppa, Md
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular occlusion
Cardiac Failure
DUE TO (b): Arteriosclerosis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Parkinson's

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan., 1967, to May, 1967, that (I) (we) last saw the deceased alive on May 9, 1967, and that death occurred at 1035 A.M., from the causes and on the date stated above.

22a. SIGNATURE: William A. Tyson — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-9-67

22c. PHYSICIAN'S NAME (Type): William A. Tyson

22d. ADDRESS: Kingsville Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: May 10, 1967

23c. NAME OF CEMETERY OR CREMATORY: Buffington Funeral Home

23d. LOCATION (City, town or county) (State): Valley View, Pa.

24. FUNERAL DIRECTOR — ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009

25a. REC'D BY REGISTRAR DATE: MAY 11 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06735 06722

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 16: 35 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d. STREET ADDRESS: 701 S. Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Edna — Middle: Winkler — Last: Maloney

4. DATE OF DEATH: Month: 5 — Day: 14 — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☑

8. DATE OF BIRTH: 5/25/1893

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Wilmington Del.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas R. Winkler

14. MOTHER'S MAIDEN NAME: Dora J. Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT: Mrs. Lucy McMaster — Address: 806 S. Washington St. Havre de Grace Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Gastrointestinal Hemorrhage	2 days
DUE TO (b)	Malignancy of G.I. tract	2-3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): A.S.C.V.D. and Nutritional Anemia + Hypoproteinemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 14th, 1967, to May 13th, 1967, that (I) (we) last saw the deceased alive on May 13th, 1967, and that death occurred at 10:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Edward C. Woods M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/15/67

22c. PHYSICIAN'S NAME (Type): Edward C. Woods M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 5/17/67

23b. DATE THEREOF: 5/17/67

23c. NAME OF CEMETERY OR CREMATORY: Riverview

23d. LOCATION (City, town or county) (State): Wilmington Del.

24. FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros.

ADDRESS: Havre de Grace, Md.

25a. REC'D BY REGISTRAR DATE: MAY 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06736

CERTIFICATE OF DEATH

06723

1. **PLACE OF DEATH**
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
   c. LENGTH OF STAY IN 1b: N/A
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: New Jersey — b. COUNTY: Burlington
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willingboro
   d. STREET ADDRESS: 16 Gamewell Lane
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James — Middle: D. — Last: MATTHEWS

4. **DATE OF DEATH**: Month: May — Day: 15, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 2,1947

9. AGE (In years last birthday): 19 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James J. Matthews

14. MOTHER'S MAIDEN NAME: Dorothy Anderson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes 12 October 66 - 15 May 67

16. SOCIAL SECURITY NO.: 230-66-8322

17. **INFORMANT** Address: DA 41 Personnel Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Fractured skull
   DUE TO
   (b):
   DUE TO
   (c): Automobile Accident
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   INTERVAL BETWEEN ONSET AND DEATH: Immediate

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was a passenger in an auto involved in an accident.

20c. TIME OF INJURY Month, Day, Year, Hour a.m. / p.m.: 1:00 p.m. May 15, 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): JFK Hwy Rte 95

20f. (City or town) (County) (State): Whitemarsh, Baltimore, Md.

21. I certify that ☒ (this hospital) attended the deceased from 15 May, 19 67, to 15 May, 19 67, that ☒ (we) last saw the deceased alive on DOA 15 May 19 67, and that death occurred at 2:00 AM, from causes and on the date stated above.

22a. SIGNATURE: Thomas Fraher MD — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 15 May 1967

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, M.D.

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 17 May 67

23c. NAME OF CEMETERY OR CREMATORY: St Marys Cemetery

23d. LOCATION (City or Town) (County) (State): Mt Holly, New Jersey

24. FUNERAL DIRECTOR: Welsh Waconda Sr. — ADDRESS: Tarring Funeral Home, Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 18 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06737

CERTIFICATE OF DEATH

06724

1. PLACE OF DEATH
a. COUNTY: HARFORD
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 7 hours
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: Rt 3 Box 311
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle L. Last MILLER

4. DATE OF DEATH: Month MAY Day 7 Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 19 February 1918

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress-Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurants

11. BIRTHPLACE (County & State, or foreign country): Harford Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Mathews

14. MOTHER'S MAIDEN NAME: Lillian Wolfington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-01-9734

17. INFORMANT: CLAUDE MILLER, Rt 3 Box 311, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 7 May, 19 67, to 7 May, 1967, that (I) (we) last saw the deceased alive on 7 May 19 67, and that death occurred at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: Thomas Fraher MD M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 7 May 67

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, MD

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10 May 67

23c. NAME OF CEMETERY OR CREMATORY: Grove Cemetery

23d. LOCATION (City, town or county) (State): Aberdeen, Maryland

24. FUNERAL DIRECTOR: Waters Accomac Sr

ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 10 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06738

CERTIFICATE OF DEATH

06725

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH: a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL-ABERDEEN 21001
c. LENGTH OF STAY IN 1b: 50YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): R.D. #2 Box 308

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MD — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL-ABERDEEN 21001
d. STREET ADDRESS: R.D. #2 Box 308
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

12.1

3. NAME OF DECEASED (Type or print): First: WILLIAM — Middle: OTHO — Last: MILLER
4. DATE OF DEATH: Month: MAY — Day: 19 — Year: 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: DEC. 16, 1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM OWNER
11. BIRTHPLACE (County & State, or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES MILLER
14. MOTHER'S MAIDEN NAME: MARY BAKER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Mrs. HATTIE E MILLER — Address: ABERDEEN 21001 R.D. # 2 Box 308

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: Hrs
4221
DUE TO (b): Advanced Arteriosclerotic CV Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chr. cholecystic Fistula

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 —
20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
2Df. (City or town) (County) (State) —

21. **I certify** that (I) (this hospital) attended the deceased from Sept, 19 67, to May 19, 19 67, that (I) (we) last saw the deceased alive on May 19, 19 67, and that death occurred at 7A M, from the causes and on the date stated above.

22a. SIGNATURE: J Ralph Hosky M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 5/19/67
22c. PHYSICIAN'S NAME (Type): J Ralph Hosky
22d. ADDRESS: Churchville Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 20, 1967
23c. NAME OF CEMETERY OR CREMATORY: WESLEYAN CHAPEL CEM.
23d. LOCATION (City, town or county): HARFORD Co. (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: HAVRE DE GRACE MD
25a. REC'D BY REGISTRAR: DATE MAY 22 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A1S (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06733

CERTIFICATE OF DEATH

06726

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Edgewood Arsenal, Md.
c. LENGTH OF STAY IN 1b: approx. 6 hrs. on 28 May 67
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): USA Dispensary, Edgewood Arsenal

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Baltimore Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore, Maryland 21215
d. STREET ADDRESS: 2817 Ruscombe Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kenneth — Middle: Joseph — Last: Milloff

4. DATE OF DEATH: Month: May — Day: 28 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1945

9. AGE (In years last birthday): 22 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemical Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Fed. Civ. Svc.

11. BIRTHPLACE (County & State, or foreign country): Baltimore Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: David Milloff

14. MOTHER'S MAIDEN NAME: Florence Fischer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: 214-44-6561

17. INFORMANT: (Uncle) Robert Fischer, Baltimore, Md.
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heat stroke — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Thermal control failure
DUE TO (c): Environmental heat

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 24 August, 19 66, to 28 May, 19 67, that (I) (we) last saw the deceased alive on 28 May 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Ernest N. Moss Deputy Medical Examiner — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 27 June 1967

22c. PHYSICIAN'S NAME (Type): ERNEST N. MOSS, LTC, MC

22d. ADDRESS: USA Dispensary, Edgewood Arsenal

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 29 May 1967

23c. NAME OF CEMETERY OR CREMATORY: Tifereth Israel Anshe Sfard Cemetary

23d. LOCATION (City, town or county) (State): Rosedale (Balto. Co.) Md.

24. FUNERAL DIRECTOR: Sol Levinson & Bros.
ADDRESS: 6010 Reisterstown Rd. Baltimore, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 30 1967

25b. REGISTRAR'S SIGNATURE: Charles Juggi

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06740 — 06727

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dist Harford Memorial Hospital
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Md — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville

3. NAME OF DECEASED (Type or print): First: Thelma A. Moore — Middle: — Last: Moore

4. DATE OF DEATH: Month: May — Day: 1 — Year: 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 9, 1913
9. AGE (In years last birthday): 53 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ----------
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William P. Hawley
14. MOTHER'S MAIDEN NAME: Mattie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): No
(If yes give war or dates of service): ------
16. SOCIAL SECURITY NO.: 220-44-0542
17. INFORMANT: Edward E. Moore — Address: Perryville, Md. 21903

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald E Palmer M.D.
EXAMINER'S NAME (Type): Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air, Md.
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
22. DATE SIGNED: 5-1-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/4/1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit, Md. Cecil

24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md.
25a. REC'D BY REGISTRAR: MAY 5 1967 — DATE
25b. REGISTRAR (SIGNATURE): [illegible]

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06741 — 06728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Havre de Grace
   c. LENGTH OF STAY IN 1b: 95 yrs.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. # 2 Boy 21078

2. **USUAL RESIDENCE** (Whara deceasad lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural- Havre de Grace 21078
   d. STREET ADDRESS: R. D. # 2 Boy
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: George — Middle: L. — Last: Ostorm

4. **DATE OF DEATH**: Month: May — Day: 27 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Nov. 20 1871

9. AGE (In years last birthday): 95 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, aven if retirad): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (County & Stete, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George V. Ostorm

14. MOTHER'S MAIDEN NAME: Martha Margaret Thompson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —

16. SOCIAL SECURITY NO.: 220-30-3880 (If yes give war or detas of service)

17. INFORMANT: Mrs. Corinna S. Himes — Address: 11 Frances St. Havre de Grace Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac Insufficiency

DUE TO (b): Myocarditis

Conditions, if any, which gave rise to immediate cause (a), steting the underlying cause last. DUE TO (c): Age

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19

20d. INJURY OCCURRED: While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stete)

21. **I certify** that (I) (this hospital) attended the deceased from 1940, 19..., to 5-27-, 19 67, that (I) (we) last saw the deceased alive on 5-26, 19 67, and that death occurred at ... M, from the causes and on the date stated above.

22a. SIGNATURE: R Keyes MD — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Havre de Grace Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 29 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Wesleyan Chapel Cem. — 23d. LOCATION (City, town or county): Harford Co. (Stata) Md.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. Madison Mitchell, Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE: MAY 31 1967 — 25b. REGISTRAR'S SIGNATURE: Frances Judge

VR A15 (4)
2DM S-63

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06742

CERTIFICATE OF DEATH

06729

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Grnds
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Md. b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Grounds
d. STREET ADDRESS 2728 c West Court St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Janet Middle: M Last: PAPES
4. DATE OF DEATH Month: May Day: 13 Year: 1967
5. SEX: Female
6. COLOR OR RACE: CAU
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 Aug 64
9. AGE (In years last birthday): 2 yrs.
IF UNDER 1 YEAR: Months: 9 Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): N/A Infant
10b. KIND OF BUSINESS OR INDUSTRY: N/A
11. BIRTHPLACE (County & State, or foreign country): Harford Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. PAPes
14. MOTHER'S MAIDEN NAME: Margaret Fisher

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT Address: Mother, Same as 2 C & D

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Neuroblastoma, metastatic — INTERVAL BETWEEN ONSET AND DEATH: 8 mos.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o.m. p.m. Month, Doy, Yeor 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 13 May, 1967, to 13 May, 1967, that (I) (we) last saw the deceased alive on 13 May 1967, and that death occurred at 11:09 PM, from causes and on the date stated above.

22a. SIGNATURE: Leland W. Wight Jr. M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 13 May 67
22c. PHYSICIAN'S NAME (Type): Leland W. Wight Jr. M.D.
22d. ADDRESS: Aberdeen Proving Ground, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/16/1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery Ft. Meyer,
23d. LOCATION (City or Town) (County) (State): Va.

24. FUNERAL DIRECTOR: Walter Macomber Jr.
ADDRESS: Farring Funeral Home Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: MAY 16 1967
25b. REGISTRAR'S SIGNATURE: Florence Yeager

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06743

CERTIFICATE OF DEATH

06730

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY: Harford — MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Md — b. COUNTY: Harford
b. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Havre de Grace c. LENGTH OF STAY IN 1b: 2hrs 30 Min	c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Magnolia 12-1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital	d. STREET ADDRESS: 512 Dembytown Rd. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: Willie	Middle:	Last: Porcher	4. DATE OF DEATH	Month: May	Day: 4	Year: 1967	
5. SEX: Male	6. COLOR OR RACE: C	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: Dec. 14, 1914	9. AGE (In years last birthday): 52 yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter	10b. KIND OF BUSINESS OR INDUSTRY: Construction	11. BIRTHPLACE (County & State, or foreign country): Georgetown, S.C.	12. CITIZEN OF WHAT COUNTRY?: USA					
13. FATHER'S NAME: Willie Porcher, Sr.	14. MOTHER'S MAIDEN NAME: Janie Jackson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII	16. SOCIAL SECURITY NO.: 249-07-5170	17. INFORMANT: Mrs. Mary Peters Porcher, 512 Dembytown Rd — Address: Joppa, Md.						

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Extensive Anterior Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b): —

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO (c): Arteriosclerotic Cardiovascular Disease — 3-4 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old Posterior Coronary thrombosis. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from May 1, 1966 to MAY 4, 1967 that (I) (we) last saw the deceased alive an MAY 4 1967, and that death occurred at 11:05 A.M. P.M., from causes and an the date stated obave.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5/4/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. — 22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: May 8, 1967	23c. NAME OF CEMETERY OR CREMATORY: Ebenezer Baptist Cemetery	23d. LOCATION (City or town) (County) (State): Magnolia Harford Md	
24. FUNERAL DIRECTOR: Howard K. McComas & Son	ADDRESS: Abingdon, Md. 21009	25a. REC'D BY REGISTRAR DATE: MAY 8 1967	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06744 — 06731

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
c. LENGTH OF STAY IN 1b: 5 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Old Fallston Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fallston
d. STREET ADDRESS: (P.O.Box#63) Old Fallston Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Heidi — Middle: ~~----~~ QUESENBERY — Last: ~~Quesinberry~~
4. DATE OF DEATH: Month: May — Day: 25, — Year: 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 13, 1962
9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): Maricopa,Co., Arizona
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lonnie Ray ~~Quesinberry~~ QUESENBERY, Jr.
14. MOTHER'S MAIDEN NAME: Ruth Ann Pierce

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give wer or dates of service): ----
16. SOCIAL SECURITY NO.: none
17. INFORMANT (Father) 838-9245 P.O. Box #63 21047: Mr. L. Ray Quesinberry, Jr. Fallston, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Cerebral Neoplasm, Malignant
1930
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2De. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
2Dc. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb. 19 67 to 5/25/ 19 67, that (I) (~~we~~) last saw the deceased alive on 5/25/ 19 67, and that death occurred at 3 A.M, from the causes and on the date stated above.

22e. SIGNATURE: Kermit P. Bonovich M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 25, 1967
22c. PHYSICIAN'S NAME (Type): Kermit Bonovich M.D.
22d. ADDRESS 879-0717 Fallston, Maryland 21047

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 27,1967
23c. NAME OF CEMETERY OR CREMATORY: Mountain Christian Ch. Cem.
23d. LOCATION (City, town or county) (State): Joppa, Harf. Co., Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014
25e. REC'D BY REGISTRAR DATE: MAY 29 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

Joseph William Foster

x

x

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06745

CERTIFICATE OF DEATH

06732

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Pylesville
c. LENGTH OF STAY IN 1b: 3 Mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fawn Grove
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Violet — Middle: Viatrice — Last: Roberts

4. DATE OF DEATH: Month: May — Day: 1, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10/12/1910

9. AGE (In years last birthday): 56 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Luther Perkins

14. MOTHER'S MAIDEN NAME: Pearl Cochran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 234-54-2975

17. INFORMANT: Address: Mrs. Marie Measley, Pylesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19__ to May 1, 19 67, that (I) (we) last saw the deceased alive on May 1 19 67, and that death occurred at 5:20 P.M., from causes and on the date stated above.

22a. SIGNATURE: Josiah A Hunt M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/2/67

22c. PHYSICIAN'S NAME (Type): Josiah A Hunt MD

22d. ADDRESS: Delta, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/4/67

23c. NAME OF CEMETERY OR CREMATORY: Norrisville

23d. LOCATION (City or Town) (County) (State): Norrisville, Harford Co. Md.

24. FUNERAL DIRECTOR: Kenneth W. Osborn

ADDRESS: Stewartstown, Pa.

25a. RECD BY REGISTRAR DATE: MAY 4 1967

25b. REGISTRAR'S SIGNATURE: Helen Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removol, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06733

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS (Wheel Road): Route 3, Box 335
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CHARLES Middle Frederick Lost SANDERS

4. DATE OF DEATH: Month May Day 29 Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 9, 1948

9. AGE (In years lost birthday): 18 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TREE TRIMMER

10b. KIND OF BUSINESS OR INDUSTRY: Asplundh Tree Expt. Co.

11. BIRTHPLACE (State or foreign country): Baltimore City, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Dennis Sanders

14. MOTHER'S MAIDEN NAME: Grace Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 218-50-6177

17. INFORMANT (Mother) 838-9238 Address: RFD #3, Box #335
Mrs. Grace T. Sanders Bel Air, Maryland 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Salicylate Overdose — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ingested overdose of aspirin

20c. TIME OF INJURY Hour o.m. p.m. Month, Day, Year: 5/27 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) (County) (State): Bel Air (Harford) Maryland

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county)

22. DATE SIGNED: 5/29/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 31, 1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Meth. Ch. Cem.

23d. LOCATION (City or Town) (County) (State): Emmorton, Harford Co., Maryland

24. FUNERAL DIRECTOR: Joseph William Foster
ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: JUN 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

Joseph William Foster

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

36747 — 06734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

1. **PLACE OF DEATH**
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve de Grace
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Harve deGrace
d. STREET ADDRESS: 4113 Hamilton Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Marie — Middle: R. — Last: Schutz

4. **DATE OF DEATH**: Month: 5 — Day: 25 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 8-12-1903

9. AGE (In years last birthday): 63 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John R. Hecker

14. MOTHER'S MAIDEN NAME: Mary J. Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr Norval Schutz 4113 Hamilton Avenue #6

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: One Year
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from December 1966, to 5-25-1967, that (I) (we) last saw the deceased alive on 5-23-1967, and that death occurred at 5:05 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Peter P. Rodman, M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-26-67
22c. PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D.
22d. ADDRESS: 8 Law St., P.O. Box 548, Aberdeen, Md. 21001

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-27-1967
23c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery
23d. LOCATION (City, town or county) (State): Baltimore Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Lassahn Funeral Home 7401 Belair Road

25a. REC'D BY REGISTRAR DATE: MAY 31 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06743 06735

FOR STATE HEALTH DEPT. [VI]

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Susquehanna River

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence prior to admission)
a. STATE Md.
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point
d. STREET ADDRESS Box 456
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Junior Middle: K. Lost: Simmons
4. DATE OF DEATH Month: May Day: 22 Year: 1967
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 1-13-24
9. AGE (In years last birthday) 43 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GUARD
10b. KIND OF BUSINESS OR INDUSTRY VA Hosp Perry Point
11. BIRTHPLACE (State or foreign country) MARSHAL Co W. Va
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Z. L. Simmons
14. MOTHER'S MAIDEN NAME BERTIE L. MASON
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WW II
16. SOCIAL SECURITY NO. UNK
17. INFORMANT Mr. Dewitt Logsdon Address Moundsville W. Va. 108 Washington Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia Due to Drowning
975X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped off JFK Bridge
20c. TIME OF INJURY Month, Day, Year Hour a.m. 5-10 5-14 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) JFK Bridge
20f. (City or town) Havre de Grace (County) (State) Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, [redacted] Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Baltimore Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
22. DATE SIGNED 5-22-67
EXAMINER'S NAME (Type) Gerald E Palmer MD
Address (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE THEREOF 5/23/1967
23c. NAME OF CEMETERY OR CREMATORY LIMESTONE CEMETERY
23d. LOCATION (City or Town) MOUNDSVILLE (County) MARSHAL (State) W. VA

24. FUNERAL DIRECTOR Pennington & Son Havre de Grace Md
ADDRESS
25a. REC'D BY REGISTRAR DATE MAY 29 1967
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06748

CERTIFICATE OF DEATH

06736

1. PLACE OF DEATH
   a. COUNTY: Harford — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Haure de Grace
   c. LENGTH OF STAY IN 1b: 3 weeks
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brevin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Harford
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
   d. STREET ADDRESS: Apt # 33, 126 Hickory Avenue
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Albert — Last: Simon

4. DATE OF DEATH: Month: May — Day: 1, — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 22, 1882

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Simon

14. MOTHER'S MAIDEN NAME: L. Elizabeth Weaver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 716-09-4931

17. INFORMANT (with) 838-3655 — Address: Mrs. Elizabeth P. Simon, 126 Hickory Ave. Apt 33, Bel Air, Md. 21014

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days
   DUE TO (b): Pyelonephritis — 15 days
   Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): old age

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from April 7, 1967 to 4-30 1967, that (I) (we) last saw the deceased alive on 4-30 1967, and that death occurred at 7:30 A.M. from causes and on the date stated above.

22a. SIGNATURE: John D. Yun M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 1, 1967

22c. PHYSICIAN'S NAME (Type): John D. Yun M.D.

22d. ADDRESS: 615 S. Union Ave, Haure de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 3, 1967

23c. NAME OF CEMETERY OR CREMATORY: Rock Spring Episcopal Ch. Cem.

23d. LOCATION (City or Town) (County) (State): Forest Hill, Harf. Co. Md.

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR — DATE: MAY 2 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06750 06737

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 57 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Abingdon
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: A — Last: Smith

4. DATE OF DEATH: Month: May — Day: 13 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Nov. 29, 1903
9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cable Splicer
10b. KIND OF BUSINESS OR INDUSTRY: US Govt - Ret.
11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Gregory Smith
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1928-1940
16. SOCIAL SECURITY NO.: 214-26-8923
17. INFORMANT: Mrs. Katherine I. Smith, Address 4004 Phila Rd. Abingdon, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Arteriosclerotic CV Disease — 8 yrs
DUE TO (c): Diabetes Mellitus — 20 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to May 13, 1967, that (I) (we) last saw the deceased alive on May 13 1967 and that death occurred at 8:05 AM, from causes and on the date stated above.

22a. SIGNATURE: Ralph Hinky MD — ATTENDING PHYS. ☒ M.D. — MED. DIRECTOR ☐ — STAFF PHYS. ☐
22b. DATE SIGNED: 5/13/67
22c. PHYSICIAN'S NAME (Type): Ralph Hinky MD
22d. ADDRESS: Churchville Hav. Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 16, 1967
23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
23d. LOCATION (City or Town) (County) (State): Bel Air Harford Md

24. FUNERAL DIRECTOR ADDRESS: Howard K. McComas & Son, Abingdon, Md. 21009
25a. RECD BY REGISTRAR DATE: MAY 15 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06751 06738

1. PLACE OF DEATH
a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 109 Holloway Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle A. Last STAPLES

4. DATE OF DEATH: Month May Day 23 Year 19 67

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 14 Nov. 1888

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad (Ret.)

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Reuben Staples (D)

14. MOTHER'S MAIDEN NAME: Elizabeth Thomas (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 705-12-7880

17. INFORMANT Address: Betty Gompers, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: 2 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Bronchopneumonia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-15-67, 19___, to May 23, 1967, that (I) (we) last saw the deceased alive on May 23, 1967, and that death occurred at 8:17 PM from causes and on the date stated above.

22a. SIGNATURE: B J Plunkett Jr M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-24-67

22c. PHYSICIAN'S NAME (Type): B.J. Plunkett Jr., M.D.

22d. ADDRESS: 617 W. Bel Air Ave. Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 29 May 67

23c. NAME OF CEMETERY OR CREMATORY: Harford Memorial Gardens,

23d. LOCATION (City or Town) (County) (State): Aberdeen, Maryland

24. FUNERAL DIRECTOR: Webster Macomber Jr. ADDRESS: Tarring Funeral Home Aberdeen, Md.

25a. REC'D BY REGISTRAR DATE: MAY 26 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06752 Item #2b,c,&d Film #6390 6/23/67 PC 06739

1. PLACE OF DEATH
a. COUNTY: Harford
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Near Edgewood
c. LENGTH OF STAY IN 1b: 1
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): (Mrs. Strong Nursing Home) Old Emorton Rd.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edgewood / Towson
d. STREET ADDRESS: Shealey Ave. Strong Nursing Home
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Edward	A.	Steuart	May	4,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		1883	83 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationary Engr. -ret.	General Institutions	Maryland USA	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Richard S. Steuart	Mary Bosley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown)	(If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW I		Family records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic CV Disease — INTERVAL BETWEEN ONSET AND DEATH

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 1-1, 1966, to 5-4, 1967, that (I) (~~we~~) last saw the deceased alive on 4-1 1967, and that death occurred at 6A M, from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Gerald C. Palmer		

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Gerald C. Palmer M.D.	Bel Air Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	May 6, 1967	Mt. Maria Cemetery	Towson, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John Burns' Sons, Towson, Maryland	MAY 8 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06753 06740

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen Proving Ground
c. LENGTH OF STAY IN 1b: 2 Hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kirk Army Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: New Jersey
b. COUNTY: Burlington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverside
d. STREET ADDRESS: 512 Monroe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Patrick — Middle: J. — Last: STOER

4. DATE OF DEATH: Month: May — Day: 15 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 30, 1947

9. AGE (In years lost birthday): 19 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Benjamin Stoer

14. MOTHER'S MAIDEN NAME: Loretta McCay

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service): Yes 12 Oct 66 - 15 May 67

16. SOCIAL SECURITY NO.: 136-40-1755

17. INFORMANT — Address: DA 41 Personnel Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Injuries to head
DUE TO
(b): intra-thoraccic organs and intra-abdominal organs
DUE TO
(c): Automobile Accident
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 Hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased was the driver of an auto involved in an accident.

20c. TIME OF INJURY Month, Day, Year, Hour a.m. / p.m.: 1:00 p.m. May 15 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): JFK Hwy Rte 95

20f. (City or town) (County) (State): Whitemarsh, Baltimore, Md.

21. I certify that ☒ (this hospital) attended the deceased from May 15, 19 67, to May 15, 19 67 that ☒ (we) last saw the deceased alive on May 15 19 67, and that death occurred at 4:00 a.m., from causes and on the date stated above.

22a. SIGNATURE: Thomas Fraher MD — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS.

22b. DATE SIGNED: 15 May 1967

22c. PHYSICIAN'S NAME (Type): THOMAS FRAHER, M.D.

22d. ADDRESS: Kirk Army Hospital, APG, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 19, 1967

23c. NAME OF CEMETERY OR CREMATORY: Beverly National Cemetery

23d. LOCATION (City or Town) (County) (State): Beverly, New Jersey

24. FUNERAL DIRECTOR: Lee A. Patterson & Son — ADDRESS: Perryville, Md. — Lee A Patterson Perryville Md

25a. REC'D BY REGISTRAR — DATE: MAY 19 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06754

CERTIFICATE OF DEATH

06741

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
d. STREET ADDRESS: 1087 Ave D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Posey — Middle: Drover — Last: Sumpter
4. DATE OF DEATH: Month: MAY — Day: 12 — Year: 1967
5. SEX: MAle
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec. 30, 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boiler Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Aberdeen Prov. Gnd.
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph G. Sumpter
14. MOTHER'S MAIDEN NAME: Martha Allie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 716-01-8655
17. INFORMANT — Address: Mrs. Maggie M. Sumpter, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 Days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Generalized Arteriosclerosis — 5 yrs
DUE TO
(c): and A S C V D

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 10, 1967, to May 12, 1967, that (I) (we) last saw the deceased alive on May 12, 1967 and that death occurred at 6:20 AM, from causes and on the date stated above.

22a. SIGNATURE: Dudley Phillips M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/12/67
22c. PHYSICIAN'S NAME (Type): Dudley Phillips MD
22d. ADDRESS: DARLINGTon 2nd

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery
23d. LOCATION (City or Town) (County) (State): Port Deposit, Maryland.

24. FUNERAL DIRECTOR: Lee A. Patterson & Son
ADDRESS: Perryville, Maryland.
25a. REC'D BY REGISTRAR
DATE: MAY 19 1967
25b. REGISTRAR'S SIGNATURE: J. Charles, Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06755

CERTIFICATE OF DEATH

06742

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
d. STREET ADDRESS: N. Ridge Rd. R.D. #2 Box #14
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: C — Last: Teyhan

4. DATE OF DEATH: Month: 5 — Day: 31 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: Feb. 26, 1905

9. AGE (In years lost birthday): 62 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Insurance

11. BIRTHPLACE (County & State or foreign country): Rodman, S. Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John R. Culp

14. MOTHER'S MAIDEN NAME: Laura Alice Hefley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 250-34-3981

17. INFORMANT Husband 838-7668 — Address: Mr. William J. Teyhan, North Ridge Drive Rd #1 Box #14 Cedar Lane Bel Air/Maryland 21014

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Myocardial infarction	4-6 hrs.
DUE TO (b)	Coronary thrombosis	4-6 hrs
DUE TO (c)	Arteriosclerotic Cardiovascular Disease	3 years

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse last.

H201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 29th, 1967 to May 31, 1967 that (I) (we) last saw the deceased alive on May 31 1967, and that death occurred at 4:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: Edward C. Loo, M.D. — ATTENDING PHYS. ☒ — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED: 5/31/67

22c. PHYSICIAN'S NAME (Type): Edward C. Loo, M.D.

22d. ADDRESS: Havre de Grace, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens

23d. LOCATION (City or Town) (County) (State): Bel Air, Harford Co. Maryland 21014

24. FUNERAL DIRECTOR: Joseph William Foster — ADDRESS: W. Broadway & Williams St. Bel Air, Maryland 21014

25a. REC'D BY REGISTRAR DATE: JUN 2 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06756 — 06743

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR (RURAL)
c. LENGTH OF STAY IN 1b: 18 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RD #2 Box 289 SHUCKS CORNER

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR (RURAL)
d. STREET ADDRESS: RD #2 Box 289
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First RICHARD — Middle COULSON — Last TODD

4. DATE OF DEATH: Month MAY — Day 31 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 23 Sep. 1904

9. AGE (In years last birthday): 62 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMING

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Perryville, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ROBERT TODD

14. MOTHER'S MAIDEN NAME: ~~Mrs.~~ Margaret Coulson XXXXXXXXXX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WW-II

16. SOCIAL SECURITY NO.: 197-07-9737

17. INFORMANT: GRACE TODD (WIFE) — Address: SAME

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: LESS THAN 10 MIN.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF ~~DEATH~~

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: Philip W. Heuman M.D. M.D.
EXAMINER'S NAME (Type): PHILIP W. HEUMAN, M.D

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED: 31 MAY 1967
Address (Street, city, town, or county): 307 HICKORY AVE BEL AIR, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3 June 67
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens,
22d. LOCATION (City, town, or country): Bel Air (State): Maryland

23. FUNERAL DIRECTOR: Walter Macomber Sr.
ADDRESS: Tarring Funeral Home Aberdeen, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 5 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06757 — 06744

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
20M 5-63

1. PLACE OF DEATH
a. COUNTY: Harford
131 S. Union Avenue
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 3 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 131 So. Union AVE.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 131 So. Union AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elijah; Middle: J.; Last: Vanover

4. DATE OF DEATH: Month: 5; Day: 9; Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-26-1909

9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SETALINE BURNER OPERATOR

10b. KIND OF BUSINESS OR INDUSTRY: SHIPYARD

11. BIRTHPLACE (County & State, or foreign country): KENTUCKY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH G. VANOVER

14. MOTHER'S MAIDEN NAME: NANCY TOLLIVER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 301-01-6959

17. INFORMANT: Mrs. Emogine M. VANOVER
Address: HAVRE DE GRACE MD 21078

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory Insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): mediastinal metast.
DUE TO
(c): Bronchiogenic Carcinoma

INTERVAL BETWEEN ONSET AND DEATH: (a) 1; (b) 3 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter natura of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ....., 19....., to ....., 19....., that (I) (we) last saw the deceased alive on .....19....., and that death occurred at 10 3/4 M., from the causes and on the date stated above.

22a. SIGNATURE: Stephen Turbin M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-9-67

22c. PHYSICIAN'S NAME (Type): STEPHEN TURBIN

22d. ADDRESS: 131 South Union Avenue

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 12, 1967

23c. NAME OF CEMETERY OR CREMATORY: MEADOWRIDGE MEMORIAL PARK

23d. LOCATION (City, town or county): BALTO. CO. (State): MD

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: R. MADISON MITCHELL, HAVRE DE GRACE, MD.

25a. REC'D BY REGISTRAR (DATE): MAY 12 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06758 06745

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Street
c. LENGTH OF STAY IN 1b: 10 mos.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Box 254A

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Street 12-1
d. STREET ADDRESS: Box 254A
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice — Middle: C. — Last: Walton

4. DATE OF DEATH: Month: May — Day: 12 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-5-1920

9. AGE (In years last birthday): 46 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (County & State, or foreign country): Bel-Air, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Glasco A. Davis

14. MOTHER'S MAIDEN NAME: Edna Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-12-0306

17. INFORMANT: Mrs. Clarence E. Walton — Address: Box 254A, Street, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Malignant hypertension — 15 yr.
DUE TO (c): Arteriosclerotic Cardio cerebro vascular disease — 15 yr.

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Nov, 1957, to 12 May, 1967, that (I) (we) last saw the deceased alive on 12 May 1967, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Edwin W. Whiteford M.D. — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 16 May 67

22c. PHYSICIAN'S NAME (Type): Edwin W. Whiteford Jr M.D.

22d. ADDRESS: Whiteford Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-17-1967

23c. NAME OF CEMETERY OR CREMATORY: Chestnut Grove A.M.E. Cem

23d. LOCATION (City, town or county) (State): Rocks, Harford Co. Md.

24. FUNERAL DIRECTOR: Otelia J. Bullock — ADDRESS: 556 Lewis St Havre de Grace Md.

25a. REC'D BY REGISTRAR DATE: MAY 18 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06759 — 06746

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Harford	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Cecil
b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Havre de Grace c. LENGTH OF STAY IN 1b: 51 days	c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Rising Sun
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Citizens Nursing Home	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: HENRY	Middle: SCOTT	Last: WHITE	4. DATE OF DEATH	Month: MAY	Day: 31	Year: 1967	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH: Dec. 22 1874	9. AGE (In years last birthday) yrs.: 92	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steam Fitter Ret.	10b. KIND OF BUSINESS OR INDUSTRY: Self Employed	11. BIRTHPLACE (County & State, or foreign country): Penna, Lancaster Co.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William K. White		14. MOTHER'S MAIDEN NAME: Emma Jamison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 214-20-6426	17. INFORMANT: Merton White	Address: Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac - Renal decompensation — INTERVAL BETWEEN ONSET AND DEATH: 24 h
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ASCVD — years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 4/10, 1967, to 5/31, 1967, that (I) (we) last saw the deceased alive on 5/31 1967, and that death occurred at 5:30 A M, from causes and on the date stated above.

22a. SIGNATURE: A.W. Grigoleit	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐		22b. DATE SIGNED: 5/31/67
22c. PHYSICIAN'S NAME (Type): A.W. GRIGOLEIT	22d. ADDRESS: Havre de Grace, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE THEREOF: 6-3-1967	23c. NAME OF CEMETERY OR CREMATORY: Rose Bank Cem	23d. LOCATION (City or Town): Colvert	(County): Cecil (State): Md.
24. FUNERAL DIRECTOR: Lemon E. McMullen	ADDRESS: Rising Sun Md.	25a. REC'D BY REGISTRAR DATE: JUN 5 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Yingling	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06760 06747

1. PLACE OF DEATH
a. COUNTY: Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
c. LENGTH OF STAY IN 1b: 23 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 42 Monroe Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOSEPHINE Middle Last WILLIS
4. DATE OF DEATH: Month May Day 29 Year 19 67
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 15 Aug. 1868
9. AGE (In years last birthday): 98 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mozella Morris

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor ar dates of service)
16. SOCIAL SECURITY NO.: 212-52-7886
17. INFORMANT Address: Elsie W. Ames, Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONIA
DUE TO (b): C.V.A
DUE TO (c): ASCVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): MALNUTRITION
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 7, 19 67 to May 29, 19 67 that (I) (we) last saw the deceased alive on May 29, 19 67, and that death occurred at 6:45 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-31-67
22c. PHYSICIAN'S NAME (Type): Santiago Leyte-Vidal, M.D.
22d. ADDRESS: 114 W. Bel Air Ave. Aberdeen, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3 June 67
23c. NAME OF CEMETERY OR CREMATORY: Union Methodist Cemetery,
23d. LOCATION (City or Town) (County) (State): Aberdeen, Md.

24. FUNERAL DIRECTOR: Chester Macumber Sr. ADDRESS: Harring Funeral Home Aberdeen, Md.
25a. REC'D BY REGISTRAR DATE: JUN 2 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66